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In The
Supreme Court of the United States
October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United
States Court Of Appeals For The
Seventh Circuit

**BRIEF OF THE MISSOURI HOSPITAL
ASSOCIATION AS AMICUS CURIAE IN
SUPPORT OF PETITIONER**

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**STATEMENT OF INTEREST OF THE MISSOURI
HOSPITAL ASSOCIATION AS *AMICUS CURIAE***

This brief is submitted on behalf of the Missouri Hospital Association ("MHA") in support of petitioner, the American Hospital Association ("AHA"). The Missouri Hospital Association was an active participant in the National Labor Relations Board ("Board") hearings concerning the promulgation of the rule governing collective bargaining units in the health care industry. The MHA offered testimony through two of its leading health care executives and submitted written comments to the Board. The MHA also participated as an *amicus curiae* before the court of appeals for the Seventh Circuit and before this Court in support of the AHA's petition.

The MHA has 140 acute-care hospital members, representing ninety-eight percent of the acute-care hospitals in the state of Missouri.¹ The membership of the MHA ranges from large tertiary-care referral centers in major metropolitan areas to very small primary-care hospitals in rural areas. The diversity of the MHA membership and the general diversity of the health care industry in Missouri are of particular relevance to the issues presented to

¹ All statistical information concerning MHA member hospitals cited herein appears in *Missouri Hospital Profiles 1989*, a publication of the Missouri Department of Health, State Center for Health Statistics. The acute-care hospital figures exclude federal and state facilities, but include thirty-nine hospitals owned or operated by local governmental entities. This case is of interest to such governmental hospitals because the Missouri state agency having jurisdiction to establish bargaining units for them normally follows procedures adopted by the Board.

this Court by the AHA. The majority of the MHA's member hospitals are health care industry employers subject to the rule promulgated by the Board. As such they and the patients they serve have a significant and direct interest in the outcome of this case.

The MHA agrees with the AHA's legal position that the rule promulgated by the Board violates both the mandate of Section 9(b) of the National Labor Relations Act (the "Labor Act") that bargaining unit determinations be made "in each case," and the Congressional admonition against undue proliferation of bargaining units in the health care industry, contained in the legislative history of the 1974 Health Care Amendments to the Labor Act. The MHA relies upon the arguments made by the AHA in support of those positions. The MHA, as *amicus*, will not restate those arguments but will focus on Missouri's experience and demonstrate 1) the necessity of individualized bargaining unit determinations in light of the diverse and rapidly changing health care industry and 2) the proliferation of bargaining units in acute-care hospitals that necessarily will follow adoption of the rule.

The Board has concluded that acute-care hospitals display no differences relevant to bargaining unit determinations. The MHA finds this conclusion to be incredible and irrational in light of the wide range of hospital organizations and their relationships with their employees. In this regard, Missouri is a microcosm of the country, with major metropolitan hospitals at one end of the spectrum and small rural hospitals at the other. The MHA, as the representative of the vast majority of Missouri hospitals, believes it has information relevant to

this court's consideration of the writ of certiorari to the United States Court of Appeals for the Seventh Circuit.

SUMMARY OF THE ARGUMENT

I. The National Labor Relations Act requires that the Board determine "in each case" the appropriate unit for the purposes of collective bargaining. 29 U.S.C. § 159(b). The Board, however, has chosen to shirk its statutory responsibility by promulgating an irrebuttable rule that mandates eight units for all acute-care hospitals. The Board's dismissal as "merely minor differences" all variations among acute-care hospitals is arbitrary, capricious, and violates Section 9(b) of the Act.

A. The variations among acute-care hospitals in Missouri, as elsewhere, are substantial and are relevant to the determination of appropriate bargaining units. Factors such as size, services provided, number and classifications of employees, and administrative structure affect the manner in which employees relate to one another. These factors affect the appropriate bargaining units for those employees. Acute-care hospitals in Missouri range in size from eighteen licensed beds to 1,208 licensed beds, from twenty-eight full-time employees to 5,262 full-time employees. Services provided by acute-care hospitals range from basic inpatient and outpatient services to multi-location outpatient facilities and home health agencies. The bargaining unit rule forbids consideration of all such relevant information.

B. The rule first proposed by the Board subdivided health care institutions into 1) large acute-care hospitals

(those with more than 100 beds), 2) small acute-care hospitals (those with 100 or fewer beds), and 3) nursing homes. The Board based its decision to deem four units appropriate in small hospitals and six units appropriate in large hospitals on the fact that there is less division of labor and specialization and more functional integration of employees in small hospitals than in large hospitals. In response to criticism from the hospital industry that the 100-bed distinction was inadequate recognition of the diversity of acute-care hospitals, and criticism from union representatives that bed size did not correlate well with staff size, the Board completely abandoned its attempt to recognize any differences among acute-care hospitals and proposed that eight units be deemed appropriate in all acute-care hospitals. The Board's response was arbitrary, capricious, and ignored both the Board's own experience and the evidence placed before it in the rulemaking proceedings.

The Board's rationale for excluding nursing homes, psychiatric and rehabilitation facilities from rulemaking applies with equal or greater force to excluding acute-care hospitals. The Board abandoned its initial attempt to include nursing homes in the rule, based on the incorrect conclusion that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." 53 Fed. Reg. at 33927. Hospitals in Missouri vary more in size and provide a far wider range of services than nursing homes. Fifty-one MHA member acute-care hospitals have separate skilled nursing units in addition to acute-care beds. Psychiatric and rehabilitation hospitals are excluded from the Board's rule, but psychiatric and rehabilitation units within acute-care hospitals

are not. The factors relied upon by the Board to exclude psychiatric hospitals are relevant to the determination of the appropriateness of a bargaining unit regardless of whether the psychiatric facility is independent or affiliated with an acute-care hospital.

II. The House and Senate Committee reports accompanying the 1974 amendments to the Act contained an admonition to the Board to prevent the proliferation of bargaining units in the health care industry. The rule promulgated by the Board ignores this admonition and requires the automatic fragmentation of acute-care hospital employees into eight separate units.

A. The eight-unit rule is a significant increase over the number of units deemed appropriate by the parties and by the Board in hospital elections in Missouri. In a 1986 election at a ninety-two bed acute-care hospital the union sought two units, one of professional employees and one of nonprofessional employees. In a 1980 election at a seventy-eight bed acute-care hospital the union sought and the Board allowed two units, one of all ambulance department employees and the other of all other hospital employees. To mandate eight units at facilities such as these is undue proliferation of bargaining units.

B. In a Missouri industry that is not subject to a Congressional admonition the Board has refused to allow skilled maintenance employees to be separated from the production and maintenance bargaining unit representing all employees. An aerospace contractor with 7,300 employees in 116 different job classifications ranging from janitors and food service employees to highly skilled technical employees has one bargaining unit. A

rule mandating eight units – including a skilled maintenance unit similar to the one rejected at the aerospace contractor – for acute-care hospitals, regardless of the particularized facts at hand, is undue proliferation of bargaining units in the health care industry.

ARGUMENT

I. SECTION 9(b) OF THE LABOR ACT AND THE DIVERSE AND RAPIDLY CHANGING HEALTH CARE INDUSTRY REQUIRE INDIVIDUALIZED BARGAINING UNIT DETERMINATIONS.

Section 9(b) of the Labor Act provides, in part, that:

The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof. . . .

29 U.S.C. § 159(b) (emphasis added). The mandate of this language is clear: the Board must determine the appropriateness of bargaining units on an individual basis, considering the particular facts in each case. The Board, by promulgating an essentially irrebuttable rule for determining bargaining units in acute-care hospitals, has shirked its statutory responsibility to conduct this factual review and make individual decisions in each case.

The Board's Final Rule provides that:

Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for

petitions filed pursuant to section 9(c)(1)(A)(i) or 9(C)(1)(B) of the National Labor Relations Act . . . :

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

Final Rule, 54 Fed. Reg. 16347-16348 (1989). The only specific example of an "extraordinary circumstance" given by the Board is "a unit of five or fewer employees." *Id.* at 16348. In the Supplementary Information accompanying the Final Rule the Board reaffirmed the narrow scope of the "extraordinary circumstances exception" as previously set forth in its Second Notice of Proposed Rulemaking ("NPR II"). *Id.* at 16345. In NPR II the Board, in addressing variations between acute-care hospitals, stated that:

The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor

differences, inherent in the industry due to the multiformity of individual constituent institutions.

NPR II, 53 Fed. Reg. 33900, 33932.² This sweeping dismissal of any further consideration of the diversity of acute-care hospitals as "merely minor differences" is a flagrant violation of the "in each case" requirement of Section 9(b) and flies in the face of any realistic analysis of the health care industry. The court of appeals decision upholding the validity of the bargaining unit rule also improperly dismissed the importance of the differences among acute-care hospitals.

² The Board provided the following enumeration of "minor differences" in acute-care hospitals:

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nationwide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building.

A. The Hospital Industry In Missouri, As Elsewhere, Is Diverse And Rapidly Changing.

The variations in the hospital industry in Missouri, as elsewhere, hardly can be considered "merely minor differences" as the Board concluded. The MHA submits that such variations are substantial and are relevant to the determination of bargaining units. The Board's rule is arbitrary and capricious in that it ignores any and all differences among acute-care hospitals. In support of its position, the MHA offers the following information concerning the diversity of the hospital industry in Missouri and the relevance of that diversity to the determination of appropriate bargaining units.

1. The Variations In Acute-Care Hospitals In Missouri Are Substantial.

There are 142 acute-care hospitals in Missouri, 140 of which are members of the MHA. Of the member hospitals, seventy-two are rural and sixty-seven are urban.³ The largest member hospital has 1,208 licensed beds and the smallest has eighteen licensed beds. The member hospital with the largest staff employs the equivalent of 5,262 full-time employees; the smallest employs twenty-eight. The number of full-time registered nurses employed by member hospitals ranges from 1,201 to three.

³ The terms "rural" and "urban" as used for purposes of MHA statistics are as defined in the Medicare Regulations at 42 C.F.R. § 412.62(f).

Forty-five member hospitals have "swing beds," i.e., beds which, pursuant to federal Medicare and Medicaid statutes and Missouri regulations, may be designated from time to time either as skilled nursing care beds or acute-care beds, at the discretion of the institution. Fifty-one member hospitals have Medicare-certified distinct part skilled nursing units which are nursing home type units operated within the hospitals' facilities.

The services provided by the MHA member hospitals, and their related organizations, also vary widely. Some member hospitals provide basic inpatient and outpatient general care services while others operate, often through subsidiary corporations, activities such as home health agencies, inpatient and outpatient psychiatric units, multi-location outpatient clinics, outpatient surgical facilities and rehabilitation facilities.

In addition to its diversity, the hospital industry in Missouri, as elsewhere, is rapidly changing. With increasing frequency, health care providers are consolidating facilities and services to maximize efficiency and resources. These consolidations are taking place through mergers, acquisitions, and joint ventures. Entire health care systems are merging and reorganizing their employees and delivery systems. At the same time health care providers in urban areas are expanding their facilities through the development of satellite locations to serve patients outside the area normally served by their primary hospitals. These changes in structure and services result in changes in the number, mix and organization of employees. An irrefutable rule that sets bargaining units in concrete is inappropriate for the rapidly changing health care industry.

2. The Variations In Acute-Care Hospitals In Missouri Are Relevant To The Determination Of Bargaining Units.

Each type of hospital described above and, indeed, each hospital, has a different employee mix and a different administrative structure. They have different ratios of one type of employee to another and of all employees to patients as well as different levels of integration among various employee groups. It should not require evidence or hearings to conclude that the employees of a twenty-bed hospital in rural Missouri are organized in a different fashion than the employees of a 1200-bed hospital in metropolitan St. Louis, Missouri. The patient acuity levels are substantially higher at the latter institution than at the former. Generally speaking, the higher the acuity level of the particular institution, the more skills that must be brought to bear upon each patient's needs at the same time. Thus, the higher the acuity, the greater the functional integration of the many categories of employees needed to care for a single patient. On the other hand, the large urban institution, with thousands of employees, is more likely to be able to hire fairly narrow specialists and concentrate their responsibilities within their primary area of expertise while the small rural hospital, with far fewer employees, must ask each employee to wear more hats and fill more roles.

An example of the high level of integration of the various classifications of health care employees is found in one acute-care hospital in Kansas City, with only 240 staffed beds, where registered nurses work in fifteen departments and occupations outside the nursing department, where they serve as traditional staff nurses or

operating room nurses.⁴ These registered nurses work in utilization review, risk management, quality assessment, social services, education, a preferred provider organization, medical records, admitting, administration, outpatient clinics, radiation therapy, central services, DRG coordination and review employee health, infection control and the wellness clinic. At that institution, approximately ten percent of the nurses are in non-patient-care areas and only seventy percent are in traditional acute patient-care settings.⁵ Nonetheless, the Board would require all of these registered nurses from many different departments, who have virtually nothing in common with each other except their state licensure but a great deal in common with other employees with whom they work on a daily basis, to be lumped into a single bargaining unit separate from all other employees. Such a result confounds reason and arbitrarily ignores the fact that "in each case" and particularly in this case a different result is required.

When the Board makes a determination concerning the appropriate bargaining units at a given employer it considers how that institution functions. The Board treats a retail store with an attached warehouse differently than a retail store and a warehouse which are not attached to

⁴ See, Testimony of Dan H. Anderson, Supplemental Appendix of Plaintiff-Appellee submitted to the court of appeals for the Seventh Circuit at 482.

⁵ See, November 6, 1987 letter to counsel for American Federation of Labor and Congress of Industrial Organizations, also submitted to the Board as part of the administrative record.

each other. *Sears, Roebuck and Co.*, 191 NLRB 398 (1971). Thus, the bargaining unit configuration depends upon the business structure adopted by the employer. An analogy to the acute-care hospital setting would require consideration of factors such as whether the hospital also operates an outpatient department or skilled nursing facility and whether the employees interact or interchange. The bargaining unit rule promulgated by the Board forbids the consideration of all such relevant information.

Even absent express congressional admonition against unit proliferation, the Board has found in the public utility cases that the public's "immediate and direct interest in the uninterrupted maintenance of the essential services" required "a systemwide unit . . . in the public utility industry. . . ." *Baltimore Gas & Electric Co.*, 206 NLRB 199, 201 (1973), cited and followed in *New England Telephone Co.*, 280 NLRB 162, 164 (1986). The Board has been reluctant "to fragmentize a utility's operations" and has done so "only when there was compelling evidence" that the narrower unit "conformed to a well-defined administrative segment of the utility company's organization and could be established without undue disturbance to the company's ability to perform its necessary functions." *Baltimore Gas*, 206 NLRB at 201. These strong policy considerations apply with at least equal force to the health care industry, especially in the face of strong congressional intent which the Board so cavalierly ignored here. The Board's proposed rule ignores the well-defined administrative structures of health care providers and irrationally proposes eight units, each of which cuts across those structures.

More importantly, the rule will not even allow consideration of those factors.

B. The Board's Rule Is Arbitrary And Capricious In That It Ignores The Diversity Of Acute-Care Hospitals.

The Board's refusal to recognize the significance and relevance of the differences among acute-care hospitals is arbitrary and capricious. The Board's decision not to distinguish among acute-care hospitals is particularly illogical and inconsistent in light of the Board's reasons 1) for initially distinguishing between acute-care hospitals on the basis of size, 2) for exempting nursing homes from the impact of the bargaining unit rule, and 3) for excluding psychiatric and rehabilitation hospitals from the rule.

1. The Board's Decision To Treat All Acute-Care Hospitals Alike Is Arbitrary, Capricious And Not Based On Substantial Evidence.

On July 2, 1987 the Board issued its first Notice of Proposed Rulemaking and Notice of Hearing concerning collective bargaining units in the health care industry ("NPR I"; 52 Fed. Reg. 25142 *et seq.*). The original proposed rule applied differently to three categories of health care institutions: 1) large acute-care hospitals, 2) small acute-care hospitals, and 3) nursing homes. Large acute-care hospitals were defined as those with more than 100 patient beds. Small acute-care hospitals were defined as those with 100 or fewer patient beds. NPR I, 52 Fed. Reg. at 25149.

The Board proposed that six collective bargaining units be deemed appropriate in large acute-care hospitals: 1) registered nurses; 2) physicians; 3) other professional employees; 4) technical employees; 5) service, maintenance, and clerical employees; and 6) guards. NPR I, 52 Fed. Reg. at 25146-48. The Board proposed that four collective bargaining units be deemed appropriate in small acute-care hospitals and nursing homes: 1) all professional employees; 2) technical employees; 3) service, maintenance, and clerical employees; and 4) guards. NPR I, 52 Fed. Reg. at 25148. In explaining its decision to differentiate between large and small acute-care hospitals, the Board stated that:

[W]e think that in smaller facilities there will be found less division of labor and specialization, and more functional integration of employees' services, than normally is the case in large hospitals.

NPR I, 52 Fed. Reg. at 25148.

In its Second Notice of Proposed Rulemaking the Board abandoned the distinction between large and small acute-care hospitals. The Board stated that its decision to drop the 100-bed distinction was based on "the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term 'bed' in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the parties' general opposition to use of a distinction based on the number of beds." NPR II, 53 Fed. Reg. at 33927.

While it is true that the hospital industry in general, and the MHA in particular, criticized the 100-bed distinction, these criticisms were not based on either evidence or belief that all acute-care hospitals are alike. Quite to the contrary, the hospital industry criticized the 100-bed distinction because it did not describe or define accurately the differences among acute-care hospitals that are relevant to the determination of appropriate bargaining units. The MHA, both in oral testimony at the administrative hearings and in written comments submitted to the Board, criticized the 100-bed distinction as unreasonable because, among other reasons, (1) a 100-bed hospital is not a "large" hospital, and 2) the rule did not provide a definition of "bed." The MHA suggested that, if a rule was to be adopted, the bed standard should be based on occupied or staffed beds rather than licensed beds because many hospitals are licensed for more beds than are utilized. The MHA also suggested that small hospitals be defined as those with fewer than 400 staffed beds.

The Board's initial proposed rule recognized that there are differences among acute-care hospitals that are relevant to the determination of appropriate bargaining units. The Board observed that, based on its experience, "[i]n smaller facilities, it is likely that employees will have more contacts with one another, may to some extent perform one another's work, and generally may share interests more than groupings in larger hospitals." NPR I, 52 Fed. Reg. 15246. Instead of refining its rule in response to the criticism and evidence of the inadequacies of the proposed 100-bed distinction, however, the Board simply ignored all of its prior experience and relevant testimony, and abandoned its attempt to distinguish among acute-

care hospitals. This decision by the Board is arbitrary and capricious and is not based on substantial evidence.

The court of appeals for the Seventh Circuit recognized as "an important criticism" the hospital industry's position "that the Board's rule is arbitrary because it lumps together hospitals of different sizes and missions in different locations." *American Hospital Ass'n v. N.L.R.B.*, 899 F.2d 651, 659 (7th Cir. 1990). The court of appeals, however, rejected this "important criticism" on the grounds that the hospital industry had failed to propose "an alternative that recognized the diversity of the industry but preserved the virtues of a rule." *Id.* This rejection is based on the erroneous assumption that the hospital industry was under an affirmative duty to provide the Board with a rational and nonarbitrary rule.

The court of appeals stated that the hospital industry "joined the unions in opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." *Id.* This statement mischaracterizes the hospital industry's response to the proposed 100-bed distinction. The court of appeals implies that the hospital industry and the union representatives were in agreement in opposing the 100-bed distinction when, in fact, the hospitals and the unions opposed the distinction for very different reasons. The hospital industry argued and provided substantial evidence that the 100-bed distinction was inadequate recognition of the diversity of acute-care hospitals in that it did not take into account the number of beds actually utilized or the nature of services being provided by the hospital. The unions, on the other hand, argued that there is not an adequate correlation between number of beds and

number of staff to justify distinguishing between hospitals. 53 Fed. Reg. at 33927. The Board noted that when the parties suggested alternative bed-number distinctions some unions suggested small hospitals be defined as those with fewer than fifty licensed beds, the AHA suggested a 400-bed distinction, and other employers suggested from 250-beds to 500-beds as the line between small and large hospitals. 53 Fed. Reg. at 33927. To characterize these diverse viewpoints as agreement is misleading and not supported by the evidence before the Board or the court of appeals.

The Board correctly attempted to construct an analytical framework, based upon size, to distinguish among hospitals. It preliminarily failed to draw the line at the appropriate place and in the appropriate manner. Then, instead of reconciling the diverse suggestions and drawing a conclusion based on the evidence before it, the Board, faced with a difficult decision, simply discarded its own accurate analysis that size differentials do affect appropriateness of bargaining units. The court of appeals compounded the error by failing to understand the difference between the unions' and the industry's opposition to the 100-bed standard. The irrational result ignores the actual differences among hospitals and sanctions an arbitrary and capricious rule not based on substantial evidence.

2. The Board's Rationale For Excluding Nursing Homes Applies With Equal or Greater Force To Acute-Care Hospitals.

As described above, NPR I designated appropriate bargaining units for nursing homes. In the Second Notice

of Proposed Rulemaking, however, the Board concluded that there are "significant differences between the various types of nursing homes which affect staffing patterns and duties" and decided to exclude nursing homes from the rule. NPR II, 53 Fed. Reg. at 33928. As evidence in support of this conclusion the Board noted that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." *Id.* at 33927. This assertion simply is incorrect.

In support of its assertion the Board cited evidence that nursing home facilities range in size from ten to 500 patients. *Id.* As stated above, acute-care hospitals in Missouri vary to an even greater degree, from eighteen to 1,208 licensed beds. The Board also cited evidence concerning the differing levels of care among the three basic types of nursing home facilities: skilled nursing, intermediate care and residential care. *Id.* There are hospitals in Missouri, however, where the level of care varies to an even greater degree within one institution. As stated above, fifty-one of Missouri's 139 acute-care hospitals have nursing home type units. One hospital in Kansas City provides care ranging from acute intensive and emergency care to long term residential care, with several levels and types of care between the extremes.

If the Board's findings with respect to the nursing home industry are correct, its irrebuttable rule for the substantially more diverse and more rapidly changing hospital industry must be incorrect. The Board's rationale for excluding nursing homes from the coverage of the rule requires precisely the same finding when applied to acute-care hospitals. The result of the Board's rationale is

a rule that is arbitrary, capricious, and not based on substantial evidence.

3. The Board's Rationale For Excluding Psychiatric and Rehabilitation Hospitals Applies With Equal Force to Acute-Care Hospitals With Psychiatric and Rehabilitation Units.

The Board's reasoning concerning the applicability of the rule to facilities providing care to psychiatric and rehabilitation patients also is arbitrary and inconsistent. The rule does not apply to facilities that are primarily psychiatric or rehabilitation hospitals, but *does* apply to psychiatric or rehabilitation units within facilities that fit within the rule's definition of an acute-care hospital. Under this scheme, the employees working on one of the floors of a 100-bed psychiatric unit at a large metropolitan hospital would be subject to the rule's mandatory bargaining unit determinations but the employees working at a 100 bed psychiatric hospital would not.⁶ There is absolutely no rational basis on which to make such a distinction.

The reasons offered by the Board in support of its decision to exclude psychiatric hospitals from the rule apply with equal force to psychiatric units within acute-care hospitals. Among the reasons offered by the Board were "that unlike other acute care hospitals, psychiatric hospitals do not provide care for the physically ill," that

⁶ Both situations are found among MHA's members. In addition, forty-five acute-care hospital members have beds licensed for psychiatric services. Twenty-nine acute-care hospital members have beds licensed for rehabilitation services.

"many professionals participate hands-on with patients," that "RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators" and "that there are more paraprofessionals (mental health workers)." NPR II, 53 Fed. Reg. at 33930. These factors exist regardless of whether the psychiatric facility is independent or affiliated with an acute-care hospital.

Missouri truly is a microcosm of the health care industry. The members of the MHA do not fit some artificial hospital profile which fills the Board's need to categorize hospitals and their employees in neat pigeonholes and thereby avoid its statutory obligation to make individual findings in each case. They are real hospitals serving real people in the rural areas, small towns, suburbs and urban centers of an incredibly diverse state. They, their employees and their organizational structures reflect that diversity and it is arbitrary and capricious for the Board to ignore reality in favor of some artificial norm which exists only in the mind of the Board.

II. THE RULE VIOLATES THE CONGRESSIONAL ADMONITION AGAINST THE PROLIFERATION OF BARGAINING UNITS IN THE HEALTH CARE INDUSTRY.

In 1974, when Congress amended the Labor Act to include not-for-profit hospitals, it included in its Committee reports the following admonition:

Due consideration should be given by the Board to preventing proliferation of bargaining

units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).

By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

As the District Court in this case recognized "[t]he stakes are higher when the Board makes bargaining unit determinations in the health care field, fragmentation of the workforce is more likely and of greater concern when patient care is at issue." *American Hospital Ass'n v. N.L.R.B.*, 718 F.Supp. 704, 713 (N.D. Ill. 1989). The District Court concluded that, in promulgating a rule which "designates an absolute number of appropriate units and mandates a particular division of the workforce," the Board was not responsive to the express concerns of Congress. *Id.* at 716. The District Court based its conclusion, in part, on the fact that the rule requires the "automatic fragmentation of the workforce into eight units, without regards to the nature and extent of the health services rendered or the dynamics of a particular health care institution." *Id.* at 714 (emphasis in original). The MHA believes that the District Court's conclusion also is supported by the history of organizational activity that has occurred in Missouri, both in the health care industry and elsewhere.

A. The Number Of Units Mandated By The Rule Far Exceeds The Number Of Units Sought And Approved In Missouri Hospital Elections.

Labor organizations in this state have not hesitated to seek to represent acute-care hospital units broader than those that will be mandated by the rule. For example, in a 1986 election at Spelman Memorial Hospital (Case No. 17-RC-9796), a ninety-two bed hospital, the International Brotherhood of Teamsters sought two units, one of professional employees and one of nonprofessional employees. In an earlier election at the same institution in 1980, Local 96 of the Service Employees International Union (Case No. 17-RC-8917) sought the same two units.

In another Missouri case, the Board conducted an election in two units sought by Local 50 of the Service Employees International Union, one of all ambulance department employees and the other of all other employees at Wright Memorial Hospital, a seventy-eight bed hospital in Trenton, Missouri. In that case the finding of a separate unit of ambulance drivers and emergency medical technicians was a result of a unique organizational structure that made such a unit appropriate. *Wright Memorial Hosp.*, 255 NLRB 1319 (1981).

In its review of the Wright Memorial Hospital election the Board concluded, contrary to what might normally be found at larger or tertiary-care institutions, that all registered nurses in the hospital actually functioned as Section 2(11) supervisors and, therefore, were not employees for purposes of organization under the Labor Act. After taking extensive testimony in that case, the Board itself demonstrated why irrebuttable presumptions

and rules are not appropriate in this industry. The Board found that each unit of the hospital operated with one RN per shift and that the RNs "possess and exercise supervisory authority which requires the use of independent judgment and goes beyond the mere exercising of professional judgment." *Id.* at 1319-1320. If the Board had chosen to assume that registered nurses are registered nurses and hospitals are hospitals, it never would have taken cognizance of the organizational structure of the emergency services and the responsibilities of the registered nurses at Wright Memorial Hospital.

The disparity between the units deemed appropriate by the parties in Spelman Memorial Hospital and the Board in Wright Memorial Hospital and the units that will be deemed appropriate for these same hospitals under the Board's rule is staggering. The difference between three units and eight units constitutes undue proliferation. The rule which mandates eight units for hospitals like Spelman Memorial Hospital and Wright Memorial Hospital violates the Congressional admonition against undue proliferation in the health care industry.

B. The Number Of Units Mandated By The Rule Far Exceeds The Number Of Units Deemed Appropriate By The Board In A Missouri Industry That Is Not Subject To A Congressional Admonition Against Proliferation Of Bargaining Units.

The MHA believes that the organizational activity in other industries within the state also is relevant to the issue of what constitutes "undue proliferation." In that regard, the MHA offers information concerning Allied

Signal Corp. (formerly Bendix Corp.), a large aerospace contractor in Kansas City, Missouri.

In the mid-seventies Bendix was the subject of detailed testimony in a case before the Board. At that time Bendix employed approximately 2,200 hourly workers; in 1989 it employed 7,300. The difference in wages, hours and working conditions from top to bottom in hospitals is not greater than the differences between the top and bottom employees in the 116 different job classifications in the production and maintenance unit at Bendix. A similar analysis applies to the skill levels of hospital and aerospace employees. There are tremendous differences between the lowest level service employees and the highest level professional and technical employees in both industries. Both hospitals and aerospace contractors employ janitors and food service employees at one extreme and incredibly highly skilled technical employees at the other. When faced with these facts with respect to Bendix, the Board refused to permit a separate skilled maintenance unit, very similar to that which, by definition, would be appropriate under the acute-care hospital rule. *The Bendix Corp.*, 227 NLRB 1534 (1977).

Thus, at an aerospace contractor, an organization substantially larger and more diverse than the vast majority of hospitals in Missouri, all the employees in over one hundred job classifications are in a single production and maintenance unit, represented by one union. If this single bargaining unit structure is appropriate in an industry that has *not* been singled out as the object of a Congressional admonition against undue proliferation of bargaining units, any rule mandating eight bargaining units for

acute-care hospitals must be found to create undue proliferation.

When Congress issued its admonition against bargaining unit proliferation in the health care industry it did so after careful thought and with full knowledge of what havoc unit proliferation has caused in the construction industry. It ordered the Board to give special consideration to the effect of such a situation on hospitals. It cannot have intended that the Board give any less consideration to hospitals than it has to the aerospace industry and it cannot have intended that the Board be permitted to do by rule what the courts of appeal have not allowed it to do by adjudication.

CONCLUSION

For the foregoing reasons, and those stated in the brief of petitioner, the MHA respectfully requests that this Court reverse the court of appeals for the Seventh Circuit, find that the bargaining unit rule is invalid, and permanently enjoin the Board from applying the rule to bargaining unit determinations in acute-care hospitals.

Respectfully submitted,

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